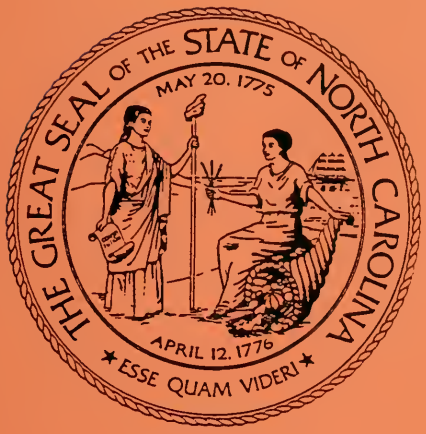

NORTH CAROLINA HEALTH PLANNING COMMISSION

RECOMMENDATIONS

December 21, 1994

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NORTH CAROLINA
HEALTH PLANNING COMMISSION
RECOMMENDATIONS

It is in the best interest of the state that every resident of North Carolina stay as healthy as possible. This requires a system which assures that preventive, primary care and other essential services are available for everyone, and that health services cannot be denied through loss of health coverage because of ill health, job status or where a person lives. More than simply affordable, health services must be available within reasonable travel distance for everyone. It ought to be easy to understand how to use the system and easy for the system to coordinate the care for each individual patient. The quality of care ought to be monitored, to ensure that all residents of the state have high quality, coordinated health services.

As simple and laudable as this vision is, it is very difficult to bring about quickly. It appears more desirable for the plan to be phased in over a period of time. Health reform began in 1993 and will not be finished for at least 20 years.[1] Between 1995 and 2000, the short term goal is that all North Carolinians will have coverage and access to essential health services. The state will make its best effort to assure that each year between 1995 and 2000, more of its citizens have health coverage. During the period of time that coverage is phased in, the state will pursue policies and funding strategies to restructure the health industry from a system focused on "sickness," to one which focuses on keeping people healthy.

The following lists the Commission's recommendations about how to move the state forward in its goal of redirecting the health system in North Carolina. The recommendations cover seven specific areas and one general area: 1) expanding coverage to the uninsured, 2) controlling rising health care costs, 3) expanding services in rural and urban medically underserved areas, 4) changing the focus of the current health system from a curative medical system to one that focuses on keeping people healthy, 5) ensuring high quality services, 6) establishing a data and information system capable of meeting the health information needs of the future, 7) ensuring that the health needs of at-risk populations are met, and 8) recommendations for the ongoing work of the Commission. The Advisory Committees that recommended the same or substantially similar recommendations are listed in parentheses.

A. EXPANDING COVERAGE TO THE UNINSURED

The Commission's recommendations recognize that both the market and government have a role to play in providing insurance coverage to those without insurance. It is the market's responsibility to make health care more available and health coverage more affordable to those with the resources to purchase coverage. It is the government's responsibility to provide assistance to those with limited resources, to enable them to obtain needed health coverage, and to make health coverage equitable. Thus, the Commission's recommendations fall into three areas: expanding Medicaid coverage to cover more people with limited resources; reforming

[1] Since most lifestyle habits are formed early in childhood, it will take at least twenty years to raise a generation of North Carolinians with healthy lifestyles. In the long term, this offers the best chance of improving the health status of the people in this state. However, in the short term, the state can do a lot by expanding insurance coverage and access to essential health services.

insurance laws to make health insurance coverage more affordable and portable; and establishing an on-going system of monitoring the numbers of uninsured.

1. North Carolina should expand Medicaid coverage to cover more pregnant women, children, aged and disabled. (Recommended by Delivery Systems, Eligibility and Enrollment, Finance and Special Populations Committees)

There are approximately 200,000 children in this state under age 18 who have no health insurance coverage,[2] and 357,700 women of childbearing years with no coverage of maternity services[3]. In addition, there are many elderly and disabled with either no or inadequate health insurance coverage. The state can provide health insurance coverage to more of the uninsured by expanding Medicaid to cover more potential eligibles. The state can expand coverage of pregnant women, children (under age 19), the elderly (65 years or older) and people with disabilities (those who meet the Social Security disability definitions) without a federal waiver under 42 U.S.C. 1396a(r). This is a relatively inexpensive way to expand coverage to the uninsured, as the federal government pays approximately 65 percent of the Medicaid costs.

The Commission recommends that the state phase in Medicaid coverage for children under age 18, pregnant women, the elderly and disabled with family incomes below 200% of the federal poverty guidelines[4] according to the following priority list. The state should expand Medicaid to the fullest extent possible, within state budget constraints. Funding for the Medicaid expansion should come from two sources: 1) additional state appropriations, and 2) savings realized in the Medicaid program through the use of managed care or gatekeeper programs.

a) Medicaid Expansion for infants under age one at 200% of the federal poverty guidelines (FPG)

Currently the state provides Medicaid coverage to infants with family incomes that are equal to or less than 185% of the federal poverty guidelines. The state's first priority for Medicaid expansion should be to expand coverage of infants to 200% of the federal poverty level. Four thousand five hundred sixty five infants would be covered by this expansion. The state will pay the state and county share. The cost of this expansion would be as follows:

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[2] Based on analysis of North Carolina sample from March, 1993 Current Population Survey, conducted by Thomas Ricketts, Cecil G. Sheps Center for Health Services Research, University of North Carolina, Chapel Hill.

[3] Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, Study of Health Insurance Coverage for Prenatal and Delivery Services in North Carolina, Ricketts, et. al., March 19, 1993.

[4] The current federal poverty guidelines (FPG) are listed below. The table includes both the annual FPG, plus the monthly limits (listed in parentheses).

Family Size	100% FPG	133% FPG	185% FPG	200% FPG
1	$ 7,360 ($613)	$ 9,789 ($ 816)	$13,616 ($1,135)	$14,720 ($1,227)
2	9,840 ($820)	13,087 ($1,091)	18,204 ($1,517)	19,680 ($1,640)
3	12,320 ($1,027)	16,386 ($1,365)	22,792 ($1,899)	24,640 ($2,053)
4	14,800 ($1,233)	19,684 ($1,640)	27,380 ($2,282)	29,600 ($2,467)

	FY 95-96	FY 96-97	FY 97-98
State	$6.2	$6.8	$7.4
County	1.1	1.2	1.3
Federal	13.5	14.5	15.6
Total	$20.8	$22.5	24.3

b) Elderly and Disabled at 100% of the Federal Poverty Guidelines

The second priority is to expand coverage of more elderly and disabled by providing coverage to those individuals with incomes equal to or less than 100% of the federal poverty guidelines. Currently, elderly and disabled individuals who are eligible for the Supplemental Security Income program (SSI) are automatically eligible for Medicaid. The SSI income limits are approximately 73% of the federal poverty guidelines. Individuals with incomes above that amount have to "spend-down" their excess income to the Medicaid medically needy income limit, approximately 40% of the federal poverty guidelines.[5] This proposed Medicaid expansion would provide coverage to all elderly and disabled with incomes up to 100% of the federal poverty guidelines, which would provide coverage to 7,000 new Medicaid eligibles, and 20,836 Medicaid for Qualified Medicare Beneficiaries (with limited coverage already). [6] The state will pay the state and county share. The cost of this expansion would be as follows:

	FY 95-96	FY 96-97	FY 97-98
State	$5.4	$11.1	$12.2
County	1.0	2.0	2.1
Federal	11.5	23.0	25.9
Total	$17.9	$36.1	40.2

c) Medicaid expansion for post-partum coverage of pregnant women with incomes at or below 185% of the federal poverty guidelines.

Medicaid currently covers the medical bills for pregnant women with incomes at or below 185% of the federal poverty guidelines. Coverage continues throughout pregnancy and for two months (60 days) post-partum. Medicaid coverage ends after 60 days post-partum, unless the woman qualifies for welfare benefits (AFDC), or qualifies for Medicaid under the medically needy

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[5] The Medicaid medically needy income limits are as follows: $242/month for an individual; $317/month for two people; $367/mo. for three people; and $400/mo. for a family of four. Thus, an elderly woman with $542/month countable Social Security retirement income would have a $300/month Medicaid deductible or "spend-down". This equals the difference between her countable income and the Medicaid medically needy income limits ($542 - $242 = $300/mo.) Medicaid eligibility is determined on a six month prospective basis. Thus, a person living on $542/month would have to incur $1,800 in medical bills ($300/mo. spend-down x six months = $1800) before Medicaid would cover any future medical care.

[6] MQB provides Medicaid coverage to Medicare recipients with incomes less than 100 percent of the federal poverty guidelines. MQB pays the Medicare cost sharing requirements (deductibles, coinsurance, etc.). It does not provide additional services, such as prescription drugs, personal care services or coverage of extensive preventive health services. Individuals entitled to full Medicaid coverage receive the more comprehensive coverage. In these cases, Medicaid is the payer of last resort (i.e., Medicare pays the bills first, and Medicaid pays the allowable differences).

program. The third priority for Medicaid expansion would be to continue out-patient coverage of pregnant women with family incomes at or below 185% of the federal poverty guidelines for two years after birth. This will provide Medicaid to more than 18,000 women after they deliver each year. Continued Medicaid coverage will provide the woman with needed out-patient medical care, coverage of parenting education classes, and counseling to help prevent unwanted pregnancies. The state will pay the state and county share of this expansion. The cost of this expansion is as follows:

	FY 95-96	FY 96-97	FY 97-98
State	$5.2	$15.4	$20.9
County	.9	2.7	3.7
Federal	11.1	32.8	44.3
Total	$17.2	$50.9	$68.9

d) Medicaid expansion for children ages one through five with family incomes at or below 185% of the federal poverty guidelines.

Medicaid currently covers children ages one through five with family incomes at or below 133% of the federal poverty guidelines. The fourth Medicaid priority would be to expand the income eligibility of younger children up to 185% of the federal poverty guidelines. This would provide Medicaid coverage to an additional 27,372 young children in SFY 95/96; 43,795 in 96/97 ; and 54,744 in 97/98. The state will pay the state and county share of this expansion. The cost of this expansion is as follows:

	FY 95-96	FY 96-97	FY 97-98
State	$6.9	$12.0	$16.3
County	1.2	2.1	2.9
Federal	14.9	25.7	34.6
Total	$23.0	$39.8	$53.8

e) Medicaid expansion for children ages one through five with family incomes at or below 200% of the federal poverty guidelines.

The state can continue to expand Medicaid coverage for young children by expanding coverage up to 200% of the federal poverty guidelines. This would provide coverage to an additional 15,029 children at full participation. The state will pay the state and county share of this expansion. The additional cost of this expansion is as follows:

	FY 95-96	FY 96-97	FY 97-98
State	$1.9	$3.3	$4.5
County	.3	.6	.8
Federal	4.1	7.0	9.5
Total	6.3	$10.9	$14.8

f) Medicaid expansion for pregnant women up to 200% of the federal poverty guidelines.

Medicaid currently provides coverage for pregnant women with family incomes at or below 185% of the federal poverty guidelines. The Commission's sixth Medicaid priority would be to expand coverage for pregnant women up to 200% of the federal poverty guidelines. This would provide coverage to an additional 1,632 pregnant women. Coverage would continue throughout the woman's pregnancy and for 60 days post-partum. The state will pay the state and county share of this expansion. The additional cost of this expansion is as follows:

	FY 95-96	FY 96-97	FY 97-98
State	$2.7	$3.0	$3.2
County	.5	.5	.6
Federal	5.8	6.3	6.8
Total	$9.0	$9.8	$10.6

g) Medicaid expansion for children ages six through eighteen at 133% of the federal poverty guidelines.

The state currently provides Medicaid coverage to children ages six through eighteen if their family incomes equals or is less than the federal poverty guidelines. The state can begin expanding coverage to older children by expanding the income eligibility guidelines initially to 133% of the federal poverty guidelines, and increasing coverage later, as more resources are available. This expansion would provide coverage to 64,782 additional children ages six through eighteen at full participation.. The state will pay the state and county share of this expansion. The additional cost of this expansion is as follows:

	FY 95-96	FY 96-97	FY 97-98
State	$7.6	$13.4	$18.5
County	1.3	2.4	3.3
Federal	16.3	28.5	39.1
Total	$25.2	$44.3	$60.9

h) Medicaid expansion for children ages six through eighteen with family incomes at or below 185% of the federal poverty guidelines.

The state should continue Medicaid expansion for older children by extending coverage to children ages six through eighteen with family incomes at or below 185% of the federal poverty guidelines. This would provide Medicaid for an additional 108,868 children at full participation. The state will pay the state and county share of this expansion. The additional cost of this expansion is as follows:

	FY 95-96	FY 96-97	FY 97-98
State	$20.3	$35.7	$49.4
County	3.6	6.3	8.7
Federal	43.6	76.7	105.1
Total	$67.5	$118.7	$163.2

i) Medicaid expansion for children ages six through eighteen with family incomes at or below 200% of the federal poverty guidelines.

The state should continue Medicaid expansion for older children by extending coverage to children ages six through eighteen with family incomes at or below 200% of the federal poverty guidelines. This would provide Medicaid for an additional 21,726 children at full participation. The state will pay the state and county share of this expansion. The additional cost of this expansion is as follows:

	FY 95-96	FY 96-97	FY 97-98
State	$2.5	$4.8	$6.2
County	.4	.8	1.1
Federal	5.5	10.1	13.1
Total	$8.4	$15.7	$20.4

j) Medicaid expansion for post-partum coverage of pregnant women with incomes at or below 200% of the federal poverty guidelines.

The tenth priority for Medicaid expansion would be to continue out-patient coverage of pregnant women with incomes at or below 200% of the federal poverty guidelines for two years after birth. This will provide Medicaid to 1,632 women after they deliver. Continued Medicaid coverage will provide the women with needed out-patient medical services, coverage of parenting education classes, and counseling to help prevent unwanted pregnancies. The state will pay the state and county share of this expansion. The additional cost of this expansion is as follows:

	FY 95-96	FY 96-97	FY 97-98
State	$.5	$.6	$.6
County	.1	.1	.1
Federal	1.2	1.2	1.3
Total	$1.8	$1.9	$2.0

k) Coverage for the elderly and disabled up to 200% of the federal poverty guidelines.

The state should complete its Medicaid expansion by providing coverage to the elderly and disabled with incomes at or below 200% of the federal poverty guidelines. This would provide coverage to 298,565 elderly and disabled individuals at full participation. The state will pay the state and county share of this expansion. The additional cost of this expansion is as follows:

	FY 95-96	FY 96-97	FY 97-98
State	$108.2	$190.7	$262.9
County	19.1	33.6	46.4
Federal	232.3	406.9	556.5
Total	$359.6	$631.2	$865.8

2. *Insurance Reform Options (Recommended in part by Insurance Reform, Delivery Systems, Eligibility and Enrollment and Financing Committee)*

The insurance reform recommendations are intended to help make insurance coverage more affordable, to remove barriers to coverage for those individuals with pre-existing conditions and to increase the portability of coverage when an individual changes or loses a job. The recommendations fall into two areas: changes to the group insurance laws, and changes to the non-group market:

a) Group Insurance Options[7]*:*

i) Limit the preexisting condition limitations to six months.

The current law allows a pre-existing condition limitation of up to 12 months in the group market and 24 months in non-group.

ii) Adjusted Community Rating.

The state has already begun to move towards adjusted community rating in the small group market, with variations allowed for age, gender, geography and family size. The Commission recommends that the adjusted community rating provisions be limited to age, geography and family size variations (no gender), with possible maximum bands for age. In order to assure a smooth transition to a gender neutral rate base, the Department of Insurance should be authorized to establish regulations to phase in gender neutral rates. There would be no maximum limits on variations in the rate differentials for geography, but insurance companies or health plans would have to use the same geographic rates within a geographic region established by the Department of Insurance.

iii) Guaranteed issuance; renewability of all products.

Currently, only the small group basic and standard product are guaranteed-to-issue and guaranteed renewable. This same protection should apply to all insurance products sold in the group markets. In addition, some guaranteed issue products and greater consumer protection in nongroup markets are needed.

iv) Portability.

Portability should be guaranteed between group, nongroup, public and private health care benefit plans. Currently, the consumer protections built into the small group insurance laws limiting pre-existing conditions exclusions applies only to employer group products. If the goal of pre-existing condition limitations is to encourage individuals to obtain coverage before they become sick, then there is no justification for limiting the portability provisions to employer based groups, as long as an individual has comparable insurance coverage through another source.

v) Support for the N.C. Health Plan Purchasing Alliance

The N.C. Health Planning Commission supports the ongoing work of the State Health Plan Purchasing Alliance Board in developing small group purchasing alliances. The efforts of the purchasing alliances to lower the costs of health insurance to small employers should help

[7] Groups include one life self-employed individuals.

encourage more small employers to offer or maintain their health insurance coverage for employees.

vi) Consumer Protection/Financial Solvency.

Over the past two decades, self-funded benefit plans have become increasingly prevalent. While these arrangements have proven valuable for managers/consultants and large numbers of employees, there have been numerous cases of employees and providers being left with large bills where the companies have not had the financial resources needed to protect themselves and their employees (and their dependents) against loss resulting from a failure of the benefits plans to meet its obligations. North Carolina has a duty to insure that its workers receive the health benefits they have been promised.

In an effort to better protect consumers and businesses, the regulation of stop-loss products sold in the market is needed. North Carolina should amend the General Statutes to regulate excess loss or "stop/loss" coverage for plans that are not fully insured. The aggregate retention point at which excess loss provisions are effective should not be less than the greater of (a) 120 percent of the expected claims for the plan or (b) $150,000 for one plan year. Additionally, if the policy establishes an individual retention point, the point must not be less than $25,000.

In addition, at least one member of the Commission indicated that penalties set forth in GS 58-50-40 (willful failure to pay group insurance premiums) and GS 58-50-45 (notice requirements of intention to stop payment of premiums) should apply to all employers, not just to those which provide insured plans.

vii) Study ways to maximize employer based coverage.

The Health Planning Commission should study ways to maximize "employer based" coverage, and more particularly, facilitating the payment of premiums on a before tax basis. Even where employers do not contribute any premium, allowing individuals to purchase coverage for themselves on a pre-tax basis (in a "125 plan") would effectively reduce the cost of premiums by 15% to 28%. Accordingly, the Health Planning Commission should evaluate the feasibility and costs involved in mandating or providing incentives for employers over a certain size to offer (but not pay for) employer based and/or payroll deduction option plans. The Health Planning Commission shall study the implications of an employer offering, but not paying for, health benefits. Specifically, the study should analyze the impact of this proposal on federal tax laws and ERISA; the effect on North Carolina's past and current efforts to expand coverage to small employers; and whether this proposal will increase the number of employees who purchase health insurance.

b) Non-Group Reform Measures (Individual Policies)

i) Portability.

The Commission recommends that all individual health benefit policies be "portable." "Portability" will help to ensure continuity of coverage. Portability allows subscribers to switch employers or insurers without a gap in coverage. Portability is designed to avoid "job-lock," which occurs when workers are deterred from switching jobs by the threatened loss of health benefits that results from waiting periods and pre-existing condition exclusions imposed by the new insurer. Subscribers, once enrolled and having met all pre-existing conditions or other limitations, should be able to transfer or obtain coverage from a new insurer, either when

changing jobs or changing insurers, without undergoing another exclusionary period, as long as the coverage is substantially equivalent to the previous benefits, and the gap on coverage does not exceed a specified period. To facilitate portability, the Committee recommends that a pre-existing exclusion be counted as applicable from any one of the following periods: (i) a previous (group or non-group) health benefits plan, (ii) Medicaid or Medicare coverage eligibility, (iii) coverage through a self-funded plan, or (iv) coverage through health insurance obtained in another state.

Portability is practical because insurance will not be sought in this situation for purposes of "adverse selection," that is, a protection against a risk already known to the purchaser of coverage. Insurance acquired when a job change necessitates new coverage need not have protections against adverse selection. Insurers can cover their risks simply by setting the initial premium appropriately.

ii) Limiting pre-existing condition exclusions

Pre-existing condition exclusions should be limited to twelve months duration for all individual health benefits plans. Pre-existing condition exclusions are defined as the refusal to cover for a defined period (sometimes forever) those medical conditions that existed at enrollment or during a defined prior period before or after enrollment. Reducing these exclusions is another method to achieve continuity of coverage. Some form of pre-existing exclusion is necessary in a marketplace in which the purpose of insurance is voluntary, in order to resist the tendency of purchasers to delay seeking coverage until they become sick, or know of a condition requiring coverage.

iii) Adjusted community rating.

The Commission recommends that the Department of Insurance be directed to phase in adjusted community rating for the non-group market over a five year period, beginning in 1996. This gradual phase-in will allow insurance carriers and health plans time to gradually adjust individual premium rates in the non-group market; and will give the Department of Insurance time to analyze the recommendations of the National Association of Insurance Commissioner's model "Nongroup Consumer Protection and Market Reform Act" which is expected to be released in June 1995.

iv) Long term care insurance.

Although only a small minority of adults do or will purchase long term care insurance, those that do will benefit from enhanced consumer protection. The Department of Insurance should develop and implement guidelines for long term care insurance dealing with 1) the rules for pre-existing conditions, 2) forfeiture of coverage, 3) inflation, 4) notification procedures regarding lapsed policies, and 5) other applicable protections.

3. *Reporting State Trends in Numbers of Uninsured (Recommended by Data Collection and Information Systems)*

The Health Planning Commission should collect data on the numbers of uninsured, as well as coverage and access issues affecting the uninsured, underinsured and non-users of the state's health care delivery system. The information should be analyzed based on age, gender, race, employment, income level, and other appropriate factors. Existing public health legislation should be modified to provide for periodic surveys or other appropriate means to be employed

for the collection of data necessary for assessing barriers to health care. The Health Planning Commission should be asked to collect this information annually, and report it to the N.C. General Assembly and the Governors Office. The cost of this survey would be $70,000 per year.

B. CONTROLLING RISING HEALTH CARE COSTS

In North Carolina, health care costs are rising more rapidly that the growth in our economy or in personal or family income. The Commission proposes to the 1995-96 General Assembly seven ways to curb rising health care costs and make coverage more affordable to middle class employees. These recommendations include: increasing the purchasing power of state government financed health programs, increasing meaningful competition among health plans, malpractice reform, strengthening Certificate of Need laws, removing the restrictions on creation of joint ventures, redefining hospital bed usage, and establishing expenditure targets to determine the relationship between health care costs and the rate of real economic growth in the state.

1. Increasing the Purchasing Power of the Government Financed Health Programs. (Recommended by Delivery Systems and Financing Advisory Committees)

In an era of limited tax resources, efforts to expand coverage to new populations dictate that government obtain the greatest feasible efficiency from the dollars it is already spending on health care for the nearly 1.4 million people for whom it is the primary payer, including: Medicaid[8] and the State Employees Health Plan.[9]

The Commission recommends that Fiscal Research identify total health care dollars spent for services (Medicaid, State Employees Health Plan, mental health, developmental disabilities and substance abuse services, public health programs, as well as health services provided through the schools and corrections system). A committee of the State's Medicaid Director, the Commissioner of Insurance, the Secretaries of the Department of Human Resources and the Department of Environment, Health and Natural Resources, the State Budget Officer, the Senate and House Appropriations Committee Chairs, Executive Administrator of the Teachers and State Employees Health Plan, and representatives of the League of Municipalities and County Commissioners Association would then be asked to evaluate and report back to the Governor, Governmental Operations and the Health Planning Commission on how governmental programs might become more prudent purchasers/arrangers of care.

One idea which the committee should explicitly explore is the possibility of combining the purchasing power of the State Employees Health Plan, Medicaid, and local government into one plan. Any savings generated from the combined purchasing power should be used, at least partially, to help offset the costs of dependent coverage, establish a model wellness program, and/or increase coverage of preventive services.

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[8] There are currently 147,600 Medicaid recipients, or approximately 15 percent of total Medicaid recipients enrolled in the Carolina Access program. The Medicaid Carolina Access program is a primary care gatekeeper program; but is not capitated. Primary care providers are given a monthly fee to manage the patient's care, and are paid on a fee-for-service basis for other services. The primary care gatekeeper must authorize referrals to specialists, but are not directly "at risk" for payments to specialists through a capitated payment. The total number of Medicaid recipients in 1994 was 956,881, Division of Medical Assistance.

[9] Of the 586,735 people currently covered by the Teachers and State Employees Comprehensive and Major Medical Health Plan, only 72,288 (15 percent) are enrolled in managed care plans.

2. *Increasing Meaningful Competition Among Plans (Recommended by Delivery Systems, Benefits Committee, and Cost Containment Advisory Committees)*

All insurance companies and health plans would be required to price, and offer on a guarantee-to-issue and guaranteed renewability basis, at least three standard products. The Commissioner of Insurance would create a committee to design standard health insurance products. The Committee would include business, insurance carriers/health plan representatives, providers, and consumers in relatively equal proportion. One plan should be the small group standard product, and two of the plans should be substantially similar to the Benefits Advisory Committee's recommendations, which includes parity for mental health and substance abuse services and full coverage of scheduled preventive services (as recommended by the U.S. Preventive Services Task Force) with no cost sharing. The Committee should periodically review the plans, eliminate and replace the plans that have been shown to be unmarketable.[10] (See Appendix A for listing of Benefits Committee recommended basic, intermediate or expansive benefits package).

3. *Malpractice Reform (Recommended in part by Cost Containment, Quality Controls, Benefits and Delivery Systems Advisory Committees)*

Any reforms intended to reduce defensive medicine must reinforce the fundamental objective of the law: the protection of patients from negligent practice and the fair compensation of those who have been injured. Reforms must both reduce the anxiety providers feel regarding the legal process and increase the quality of care rendered to patients. A less confrontational, more structured process of resolving disputes, determining responsibility and awarding compensation for injuries will reduce physicians' anxiety, and thus decrease over-reliance on defensive medicine and excessive health care costs.

a) *Alternative Dispute Resolution - All Cases Should Be Required to First Go Through Some Form of ADR Prior to Having a Trial in Court.*

The Commission recommends that all malpractice cases would be required to first go through some form of ADR. Parties should be given the choice of mediated settlement conference, early neutral evaluation ("ENE"), non-binding arbitration, binding arbitration, summary jury trial cases or other models. Information about the proposed ADR decision could not be introduced into court proceedings.

The Administrative Office of the Courts, in its current study of the ADR system, should specifically analyze the effectiveness of ADR in medical malpractice cases. The study shall include recommendations to the General Assembly about needed changes to the ADR system, including whether mandatory ADR is appropriate in all malpractice cases.

b) *Pretrial Screening - Malpractice Suits Should be Screened by a Qualified Expert Prior to Filing a Complaint or Answer.*

The Commission recommends that the plaintiff's attorney have a potential malpractice suit screened by a qualified expert of his or her choosing prior to filing a complaint in the case, and that a defense attorney have the suit screened by a qualified expert prior to filing an answer. The expert must give an opinion that there is potential merit to the suit before the suit could be filed,

[10] For example, the basic plan developed for the small group market has not proven very marketable. According to information from the NC Dept. of Insurance, only 10 small group basic plans were written in 1993.

or a potential meritorious defense. However, the expert's name would not be discoverable, in order to encourage experts to be willing to give their expert opinion and not worry about having to get involved in a lawsuit. This is similar to the practice that Medicare uses in its peer review process.

c) Qualifications of Expert Witnesses - Expert Witnesses Should be Board Certified in the Same or Similar Specialty, and Should have Prior Experience Treating Similar Patients

The statutory definition of standard of care, used to determine medical malpractice, is based on the practice among "members of the same health care profession with similar training and experience situated in the same or similar communities at the time of the alleged act giving rise to the cause of action." N.C.G.S. 90-21.12. However, under current case law, almost anyone with a medical training can be an expert in any case--regardless of their actual knowledge of the specific medical issues in the case.

The Commission recommends that the General Statutes be amended to require that experts in medical malpractice cases be board certified with the same or similar specialty and be someone who has cared for similar patients sometime in his or her practice.

d) Caps on Attorneys Fees - The State Should Establish a Sliding Scale Cap on Attorneys Fees Based on the Amount of the Award.

The Commission recommends that the Administrative Office of the Courts establish a sliding scale cap on attorneys fees based on the amount of the award (i.e., a larger percentage of the recovery would be awarded to counsel in cases with small awards. As the amount of the award increases, the percentage of the recovery going to the attorney would decrease). In establishing this cap, AOC should ensure that the attorneys fees cap is not set too low to create barriers for low income people to be able to find attorneys to represent them in these cases.

e) Subrogation - All Regulated Insurance Carriers and HMOs Should Have The Right to Seek Subrogation Against Other Parties when Found Liable for the Payment of the Costs of Health Services.

Existing insurance department regulations should be amended, or a state statute enacted, to enable insurance and HMO contracts to include subrogation clauses allowing them to be reimbursed for payments made on behalf of an insured individual arising from a incident in which they were hurt by another party, and the other party is determined to be liable for such payments. Subrogation should be limited to no more than one-third of the patient's recovery after the deduction for attorneys' fees as is presently allowed for the state in Medicaid subrogation claims. N.C.G.S. 108A-57.

f) Recommended Payment Schedule for Physical Injury as well as Pain and Suffering

The Administrative Office of the Courts, with the advice of medical and legal experts and economists, should create a recommended schedule of awards to be given to potential juries for all physical injuries, including pain and suffering. This schedule would be advisory in nature, and would not contain maximum caps on awards.

g) Studying a No-Fault System

The Commission recommends the creation of a Malpractice Legislative Research Study Commission to study the idea of establishing a no-fault system for all medical malpractice suits, similar to the workers compensation system, or a more limited no fault system for specific types of injuries. Under such a system, any person who was injured through a medical action or lack of action, would be entitled to some compensation for their injury. There would be no need to show fault on the part of the practitioner, which should help eliminate or reduce defensive medicine that is based on the fear of malpractice suits. Individuals would still have the right to sue a practitioner directly for gross, malicious or intentional misconduct. A no-fault system would also make the system more accessible to the people who have been harmed by negligence, but who never file claims. The findings and recommendations of this study shall be presented to the Health Planning Commission and the N.C. General Assembly no later than March 1, 1997.

4. Strengthening Certificate of Need laws (Recommended by Cost Containment Advisory Committee)

a) North Carolina should eliminate the existing statutory exemption of HMOs from the CON process.

Fundamentally, the Certificate of Need law must establish a "level playing field" for the private sector delivery of health care. Thus, there should be no exemptions from the CON laws for HMOs, or any other type of provider. There is substantial underutilization of nearly all acute care services and thus little need to provide exemptions from CON requirements for HMOs. Thus the Commission recommends that the CON legislation be amended to eliminate the existing statutory exemption of HMOs from the CON process.

b) Operating rooms in all locations and recovery beds in ambulatory surgery facilities should be made subject to CON review, regardless of cost.

Operating rooms of ambulatory surgery facilities and hospitals, and recovery rooms of ambulatory surgery facilities, are seriously underutilized. Existing providers can expand their existing facilities without a CON if it is done in increments of less than $2 million. This creates a serious inequity between existing providers and any potential new providers as low utilization obviates the need for new facilities. The Commission therefore recommends that CON be amended to cover changes in operating rooms and recovery beds of ambulatory surgery facilities and hospitals.

c) "Linear accelerators" should be added to the list of items specifically requiring a CON and the statutory reference to Oncology Treatment Centers should be eliminated.

The 1993 session of the General Assembly added "Oncology Treatment Centers" to the list of health facilities. In fact, the only way a facility becomes an Oncology Treatment Center is by purchasing and using a linear accelerator. Therefore, the Commission recommends that the major medical equipment, rather than the type of service, should be regulated.

d) *North Carolina should add specific items to the list of major medical equipment requiring a CON, or lower the financial threshold for major medical equipment requiring a certificate of need, rather than regulating diagnostic centers.*

"Diagnostic Centers" were added as health service facilities in 1993. Diagnostic centers are defined as facilities having more than $500,000 invested in equipment costing $10,000 or more per machine. The state has limited resources, and it is not efficient to educate, identify and regulate the many facilities that fall under this definition. The Commission recommends that the state regulate the major medical equipment used in these facilities rather than regulating diagnostic centers.

e) *Facilities offering health care services that utilize mobile major medical equipment should be required to obtain a CON.*

The purchase of mobile equipment now requires a CON. The leasing of such equipment by providers, however, is not subject to the law. In order to avoid unnecessary duplication, the Commission recommends that leasing as well as purchase of mobile equipment should be subject to the same requirements.

5. *Remove restrictions on the creation of joint ventures.*

a) *The state should facilitate efficient mergers to lower total cost, with North Carolina providing review of potential mergers to ensure that they serve the public interest.*

The Hospital Cooperation Act of 1993 should be amended to apply to health care providers other than hospitals. This amendment will have a pro-competitive effect by lowering administrative costs, creating economies of scale from mergers, elimination of duplicative equipment, furthering uniform quality control and utilization review procedures and improvement of access to health care in North Carolina's rural areas.

b) *Restrictions on the creation of joint ventures by public health institutions with private health care institutions should be removed from state statutes.*

Public hospitals now are prevented from restructuring to control costs—they are unable to do many of the things private hospitals can do to form integrated delivery system networks which will lower costs. Public hospitals, as agents of their counties, may only take such action that is statutorily authorized and not constitutionally prohibited. Although there is now statutory authority for public hospitals to enter into any arrangement, such as joint ventures with private parties, these ventures may still be restricted to the extent applicable by the public purpose clause of the state Constitution. One way to help level the playing field between public and private hospitals would be to clarify that public hospitals can enter into capitation contracts and joint ventures in the development of integrated delivery systems, and that these arrangements will serve a public purpose. Such joint venture entities should be subject to normal capital requirements and solvency oversight. Other methods to level the playing field may include: amending N.C.G.S. 160A-20 to include public hospitals. (This statute permits the purchase or financing of real property or improvements with certain restrictions). Similarly, the state could amend N.C.G.S. 14-234(a) and 131E-21 to clarify that it is not a conflict of interest to establish physician-hospital organizations (PHOs) in which physician-directors also participate as contract providers of medical services to the PHO's managed care patients.

6. *Redefining Hospital Bed Usage*

a) *Establish a capital fund to allow rural hospitals and other institutions in underserved areas to convert their physical plants to more appropriate uses.*

The General Assembly should amend N.C.G.S. 131A to allow the Medical Care Commission to provide partial loan guarantees to accommodate smaller, higher risk health care organizations. An appropriation of $2.5 million in FY 95-96 and $2.5 million in FY 96-97 would be needed to guarantee the loans.[11]

b) *Provide financial incentives for sound emergency medical systems in underserved areas without full-service hospitals.*

For a lot of small towns, the emergency room is the most viable and needed service that the hospital offers. Communities might be willing to eliminate acute care beds, if the community could maintain their emergency services. The Department of Human Resources, in conjunction with the N.C. Hospital Association and the N.C. College of Emergency Physicians, and the N.C. Association of Paramedics should study this issue, and what incentives are needed, if any, to help maintain needed emergency services when hospital beds are reconfigured. The Department should report its recommendations to the Health Planning Commission on or before October 1, 1996 for possible introduction into the 1997 General Assembly.

c) *Encouraging the conversion or redirection of inefficient hospitals and elimination of unneeded services.*

The Department of Human Resources should undertake activities that would encourage the optimization, redirection, and/or conversion of structurally inefficient hospitals and elimination of unneeded services.

7. *Assessment of total health expenditures to determine how closely the increases in health care costs parallel the rate of real economic growth in the state.*

The Commission recommends that the Health Planning Commission establish target health expenditures for both the public and private sectors, for the current year, and for five years ahead. This shall be used to judge whether increases in expenditures are being appropriately contained and as a means to judge the cumulative effect of the state's and private sector's various cost containment measures. Costs assessments should be developed for (1) total expenditures, (2) public (federal, state and local) expenditures (including figures for Medicaid, state benefits, etc.), (3) private expenditures (including figures for traditional insurance, HMOs, individual out-of-pocket and uncompensated care), and (4) types of service (i.e., primary, secondary or tertiary care, physician or hospital care). These categories (and/or others deemed appropriate by the responsible agency) should be cross-cut by both public and/or private source of payment and type of service provider. A fundamental principle should be that expenditures on each category should not increase more than the rate of real economic growth. Figures shall be updated at least every five years and shall be used to evaluate whether expenditures are being managed to determine the sectors of the health care system which are growing the fastest and, most importantly, to educate the public and government leaders about the real cost of delivering health

[11] This money would only be spent in the unusual circumstances of a loan default.

care to North Carolinians. In addition, focusing attention on the increases in cost will help identify the actual causes of excessive expenditures and assist in the containment of costs.

8. Other Cost Containment Items.

a) N.C. Information Highway.

The Commission supports the development of the North Carolina Information Highway and other information systems which would facilitate communication among geographically distant providers. Among these systems are automated patient databases, electronic billing systems, and telemedicine opportunities. The Commission recommends that the N.C. Health Information and Communication Alliance place priority on expansion of telemedicine programs which would be used to develop a model collaborative practice of primary care providers able to work together and communicate instantaneously with one another, and with specialists providing needed consultative services, even though working in geographically distant locations.

b) Conflict of interest legislation.

The Department of Human Resources should review the conflict of interest legislation enacted in 1993, N.C.G.S. 90-405 *et. seq.* to consider whether further legislation is necessary to prevent physician referrals to facilities and services in which they have any type of beneficial interest. The Department of Human Resources should specifically study whether further legislation is needed to prohibit providers from indirectly owning the equipment to which they refer patients, and prohibit either internal or external referrals from which they receive any economic benefit. It may be appropriate to permit exceptions to this rule for tests in doctors' offices, such as x-ray examinations, where use of the equipment is an integral part of serving the patient efficiently and effectively. The Department of Human Resources shall report its findings to the Health Planning Commission on or before March 1, 1996.

C. EXPANDING HEALTH SERVICES INTO RURAL AND URBAN MEDICALLY UNDERSERVED COMMUNITIES

The state must design strategies to ensure that rural and urban medically underserved communities have adequate health resources to meet the needs of the communities. While the most critical need is to ensure sufficient numbers of primary care providers, medically underserved communities must be assured access to preventive services as well as emergency care. Health plans and insurance companies should help support and expand existing resources in medically underserved areas, and should be discouraged from practices which drive primary care providers out of rural and urban medically underserved practices. The Commission's recommendations on how to strengthen the medical infrastructure in isolated communities include: measures aimed at reducing the financial disincentives to practice in medically underserved communities; recruitment and retention strategies; strategies to build the infrastructure in medically underserved areas; expand insurance coverage in medically underserved areas; and methods to increase the number of primary care providers available to practice in medically underserved communities.

1. *The state must provide financial incentives to practice in medically underserved areas. (Recommended by Rural and Urban Medically Underserved Communities, Primary Care)*

There is currently a large disparity between salaries paid to primary care providers practicing in rural areas versus those in the larger urban areas. For example, the starting salary for primary care physicians offered by the Rural Health centers throughout the state ranges from $60,000-$90,000/year; while the average starting salary offered to primary care physicians in the larger urban areas ranges from $120,000-$130,000/year.[12] The state should help remove or reduce the financial disincentives to practicing in rural or urban medically underserved areas.

The state should enhance Medicaid reimbursement and add a bonus for primary care providers serving in medically underserved areas who are not currently covered by cost-based reimbursement. These payments should be made only to providers who serve a significant proportion of their service area's Medicaid population. Further enhancements should be made to qualifying primary care providers by adding a 1-2 percent bonus for each of the following community needs: participate in a group practice or network, utilize mid-level providers, practice obstetrics, teach residents and medical students, provide health department services, participate in hospital practice, backup state Rural Health Clinics, provide nursing home care, or establish satellite clinics. The cost to enhance the Medicaid rate for primary care providers in health shortage areas by 35% is projected to be $21.3 million; funded by $13.8 in federal receipts and $7.5 million in nonfederal dollars ($6.4 state and $1.1 local)

2. *Recruitment and Retention of Primary Care Providers into Medically Underserved Communities (Rural and Urban Medically Underserved Communities, and Primary Care Advisory Committees)*

a) *Provider incentive fund.*

Create a Provider Incentive Fund by pooling together existing funds. To recruit and retain providers, the Office of Rural Health and Resource Development currently has separate funds for loan repayment, residency stipends, bonuses, and other incentives. By granting the Office the flexibility to pool existing funds, the effectiveness of these funds can be raised without increased funding. Without flexibility, in any given year, the Office often experiences excess demand for one type of assistance while having excess moneys and lower demand for another type of assistance. Provider needs change each year, yet funding amounts remain constant. Pooling the funds would allow staff to respond to changes in the market and be able to recruit more providers using appropriate incentives. There are no new appropriations needed for this proposal.

b) *Locum tenens program.*

The Office of Rural Health and Resource Development should develop a *locum tenens* program to provide relief to primary care providers in medically underserved areas. Locum tenens services provide interim clinical services to patients of physicians and other providers who need to spend time away from their practice to pursue continuing medical education, in times of illness, or to have a vacation. The cost to the state is estimated to be $1 million annually.

[12] Information provided by Jim Bernstein, Director of the Office of Rural Health and Resource Development, N.C. Department of Human Resources, December 7, 1994.

3. Build infrastructure in medically underserved communities (Recommended by Rural and Urban Medically Underserved Areas, Eligibility and Enrollment and Financing Advisory Committees).

North Carolina has, for more than 20 years, invested in building a primary care system to serve underserved rural areas. This system, which is comprised of 60 locally-owned rural health centers, currently provides care to 225,000 underserved residents a year. Despite this substantial investment, there are still 62 counties or parts of counties designated Health Professional Shortage Areas by the federal government. Almost 650,000 low-income people (under 200 percent of poverty) live in the rural areas, of which, more than 300,000 still do not have access to affordable primary care services. In urban counties, almost 300,000 low-income people (under 200 percent of poverty) live in HPSAs. Approximately half of these urban residents lack access to affordable primary care services. In total, about 22 percent of North Carolina's residents live in areas with a significant shortage of primary care physicians.

To address the primary care needs of the remaining underserved rural population, as well as to address the primary care needs of the underserved urban population, the Commission recommends:

a) Develop new and expand existing primary care centers.

Expand the existing primary care system by assisting underserved communities to develop four new health centers a year and by expanding four existing primary care centers a year. It is estimated that this expansion in service capacity would enable the system to serve an additional 30,000 patients each year. As a result, after three years almost 100,000 additional patients will have a primary care provider.

Cost: $1.5 million a year in capital grant funding
$1.5 million a year in operational grant funding
Total: $3 million state appropriation annually

b) Expand existing rural health centers.

Provide one-time biennial funding to enable many of the existing 60 rural health centers to modernize and improve their physical plants and to strengthen their operations by enabling centers to recruit additional providers, using grant funds to subsidize salaries while their practices are built. This will increase the capacity of existing rural health centers to serve additional patients.

Cost: $4 million in one-time capital funding
$3.5 million in one-time operational funding
Total: $7.5 million

c) Form Integrated Service Networks.

Incentives should be put into place that lead to the development of seamless health care systems--integrated services networks--for rural and urban underserved populations. These networks would link primary care facilities, small rural hospitals in smaller communities, and urban underserved neighborhoods to larger secondary and tertiary care centers. Incentives for rural and underserved providers should be designed so that services are coordinated and case management is provided for at-risk populations. The networks would enable smaller providers to attain the

most appropriate intervention for their patients. States such as Minnesota and Washington have developed similar network-enabling programs, yet a state specific model should be designed for North Carolina providers. The cost of this proposal is $100,000 for planning grants and additional funding for one F.T.E. staff to provide technical assistance.

d) Creation of Human Resource Authorities.

Legislation should be drafted to allow the Department of Human Resources and the Department of Environment, Health and Natural Resources to allow counties and/or multi-county consortia to form Human Resource Authorities, which can centralize funding, administration, and delivery of public health, mental health and social services. Many patients currently travel to multiple human service agencies in order to fulfill their health care needs. This would permit counties and multi-counties to consolidate resources, and operate services in a more streamlined fashion.

4. *Expanding Insurance Coverage in Medically Underserved Areas (Delivery Systems, Rural and Urban Medically Underserved Communities, Primary Care, Community Health Districts)*

a) Health plans and carriers must cover entire region.

Carriers or health plans that offer services in one part of the community health district or geographic regions designated by the state should be required to offer services throughout the entire region. This would encourage carriers and health plans, who wish to sell their products in the more populated urban areas, to help support existing providers or develop new resources in medically underserved areas. The Committee recognized that there may be times when a health plan cannot offer services in a particular community despite their best efforts to do so, for example--if providers in a particular community refused to contract with a HMO because they opposed capitation. The Committee recommended that the Department of Insurance be authorized to grant time limited exceptions for plans who, for good cause shown, have been unable to develop their provider network in the entire district. The exception would be for a set period of time to give the carrier or health plan the ability to bring in or develop its own resources in the affected communities.

b) Essential community provider protections.

Implement "essential community provider" provisions that enable certain rural or urban primary care providers, those who served significant percentages of Medicaid, Medicare, at-risk or indigent patients in medically underserved areas, to participate in managed care networks for three years while providing incentives for them to form local provider networks.

5. *Expand the Number of Primary Care Providers Available to Serve in Medically Underserved Areas*

The state also needs to expand the number of primary care providers, in order to meet the primary care needs in both urban and rural medically underserved areas. The Commission's recommendations include:

a) Create statutory definition of primary care.

A new definition of "primary health care," as defined below, should be adopted by the General Assembly, state health occupational licensure boards, health-related professional associations including the medical societies and health care provider associations. The definition should be used to provide a framework so that by 2000 three goals can be reached: a) Medical and health professional education curricula can be reoriented to produce physicians, physician assistants, certified nurse midwives and nurse practitioners able to satisfy the definition; b) Each appropriate professional licensure board can develop and implement a post-licensing credentialing category called "primary health care" (physician), (nurse practitioner), (physician assistant), (certified nurse midwife), etc., based on the definition; c) Reimbursement, from both public and private sources, for "primary care" services shall only be made to those providers credentialed as such by the appropriate state licensing boards.

Legislation should be based on the following definition of primary care:

> "Primary care is that health care provided by physicians, physician assistants, nurse practitioners and certified nurse midwives prepared by education, disciplinary training and experience to give it. It is health care based on a sustained relationship between the clinician and the individual seeking such care, established for the purpose of preventing injury and illness, promoting mental and physical wellness and providing early and continuing intervention in the management of acute and chronic illness.
>
> This relationship is established with the mutual expectation of continuation over time, regardless of the individual's health state, and is predicated on the development of mutual trust and respect, a commitment by each party to the relationship and to working cooperatively to achieve the intended purposes.
>
> Both the clinician and the individual have responsibilities whose fulfillment is required for the relationship to be successful in achieving its purposes and to constitute primary health care.
>
> It is the clinician's responsibility to provide health care which is continuing, comprehensive and integrated and which is accessible to the individual, technically sound and appropriately adapted to the individual's preferences, sociocultural context, work environment, role demands and health state. Primary health care must include all of the above, not one or several.
>
> It is the individual's responsibility to seek continuing care directly from the primary health care provider, unless otherwise advised by the provider, to adhere to the health plan, treatment advice and referral advice discussed and agreed upon and to communicate all information needed to permit the provider to adapt plans and advice to the individual's preferences, sociocultural context, work environment, role demands and health state."

See Appendix B for Questions and Answers

b) Reorienting Education Toward Primary Care.

North Carolina's state medical schools and health professional schools should reallocate existing budgets to fund the educational programs to produce more primary health care providers—physicians, nurse practitioners, physician assistants and certified nurse midwives. North Carolina should expand the number of primary care residencies, and develop an equitable form of state-funded payment for assisting those practice sites participating in the teaching of medical, physician assistant, nurse practitioner and certified nurse midwife students. This recommendation would not entail new resources, as existing resources of the state's medical and nursing schools could be reallocated away from specialty training into increased primary care education programs.

The state should also provide financial support to health professional schools that (1) offer outreach programs in geographic areas with high percentages of under-represented racial and ethnic groups, and/or (2) offer courses during nontraditional and flexible hours to accommodate students with young families or daytime jobs. The recurring cost of this proposal would be: $1.8 million annually.

c) Developing plans to increase mid-level primary care providers.

The ongoing "plans" required by N.C.G.S. 143-613 (a)-(e) from North Carolina's public and private medical schools for increasing the number of primary health care physicians should be expanded to also include plans from health professional schools regarding methods for increasing the number of mid-level primary health care providers. The requirement that the Board of Governors of the University of North Carolina annually report to the General Assembly on the graduation rates and career choices of primary health care physicians should be amended to obtain: (1) similar data on mid-level primary health care providers, and (2) annual revisions (as needed) to the plans prepared by the state's private and public medical and health professional schools to increase the number of physician and mid-level graduates entering primary health care careers.

d) Encouraging Collaborative Practice.

The North Carolina Chapter of the American College of Nurse Midwives, the North Carolina Nurses Association, the North Carolina Academy of Physician Assistants, the N.C. Academy of Family Physicians, NC Academy of Pediatrics, NC Society of Internal Medicine and the North Carolina Medical Society should jointly develop a definition of, and rules for, collaborative practice which can be proposed to the General Assembly in its Short Session in 1996, as well as to the Board of Medical Examiners and the Board of Nursing. The definition should be used as the basis for regulatory activity by the licensing boards. It may be also enacted into law, if appropriate, to guide and encourage the development of collaborative practices.

Professional practice rules, state licensing standards, public and private reimbursement policies and medical and health professional educational programs should be reoriented towards the development of collaborative practices between and among primary care health care physicians and mid-level providers.

The general statutes guiding professional corporations, which currently permit only physician-to-physician incorporation, should be amended. The law should permit professional incorporation across professional boundaries to include those mid-level primary health care providers permitted to practice under the Medical Practice Act (physician assistants, certified nurse

midwives and nurse practitioners), in order to permit corporate primary care organizations including mid-level providers and/or mid-level providers and physicians.

e) Non-Discrimination in insurance reimbursement against mid-level practitioners.

By statute, North Carolina should prohibit insurers from refusing to provide payment to practices owned in part, or in whole, by nurse practitioners, physician assistants or nurse midwives who are practicing within the scope of practice specified under North Carolina statutes and who are providing services recognized as beneficial and cost-effective by recognized professional authorities.

D. IMPROVING HEALTH STATUS

North Carolina compares favorably with other states and countries on the amount of expensive, high technology equipment per capita;[13] and on the resources available through our tertiary, academic teaching institutions. Yet, North Carolina ranks very low on basic health status indicators, such as infant mortality, life expectancy, morbidity and mortality indicators. For example, North Carolina has a higher rate of deaths due to heart disease, higher rates of cancer deaths among males, higher infant mortality rate, higher teen pregnancy rate, and higher rate of primary and secondary syphilis cases than the national average.[14] Clearly, the state can do more to improve the health status of the people of the state.

1. Mandate that health plans provide coverage of certain effective preventive care services (Benefits Committee, Cost Containment Committee).

The Commission recommends that the state mandate coverage of certain preventive services, including prenatal care, well child care [15] and immunizations, which have been shown to be cost-effective. In addition, the Department of Insurance should establish an ongoing committee evaluating the effectiveness of other preventive health services, and should report back to the Health Planning Commission and the N.C. General Assembly each biennium on other services which should be included in health insurance plans because they have been shown to be cost effective.

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[13] Information provided by Robert J. Fitzgerald, Assistant Director, Division of Facility Services, NC Department of Human Resources; Presentation by Dr. Sandra Greene to NC Health Planning Commission, August 23, 1994. See Blue Cross Blue Shield Annual Report

[14] *"Health Care Profile: The Nation and the Sunbelt Region,"* Congressional Sunbelt Caucus, March 1994.

[15] At least 11 states mandate that insurance plans cover some well-child services, including: Florida (birth to age 16, must cover 18 well-child visits, no deductibles allowed); California (birth through 16); Connecticut (birth through six, 13 well-child visits); District of Columbia (unlimited visits, birth through age 12, three visits per year children 12-18); Hawaii (birth through five, up to 12 visits); Iowa (routine well-baby care for infants through age two); Maryland (covers certain services according to American Academy of Pediatric periodicity schedule, no age limits); Massachusetts (birth through age six, 13 visits); Minnesota (birth through age five, up to 13 visits, no copayments or deductibles); Montana (children through age two; follows EPSDT periodicity schedules, exempt from deductibles); Ohio (birth through age nine, costs limited to $500/year infants to age one; $150/year for older children; copayments and deductibles may not be barrier to care); Rhode Island (birth through age 19; AAP periodicity schedule, no deductibles, but copayments allowed as long as not a barrier). *"Healthy Kids: States Initiatives to Improve Children's Health,"* National Conference of State Legislators, April 1993.

2. *Expand the capacity of public health departments to meet the community health priorities (Community Health Districts, Rural and Urban Medically Underserved Areas, Health Promotion, Disease Prevention and the Role of Public Health).*

a) Study capacity of public health departments.

The Legislative Study Commission on Public Health should study the capacity of small counties to meet the core public health functions mandated by current state and federal law. The Commission should consider whether the current county and district health departments should be organized into a network of larger multi-district community administrative units. In making its recommendations, the Commission shall consider: whether the state should establish minimum populations for local health departments; a suggested number of and configuration for these multi-county administrative units; and a series of incentives to ease county transitions into these new arrangements.

b) Healthy Community block grant.

The state should establish a Healthy Community block grant to allow counties to focus on health programs/issues determined through a community health assessment process, to be urgent needs. Counties may choose to focus on any of the core public health functions. The cost of this program to the state would be: $2 million each biennium over the next three bienniums.

c) Expanded Capacity for Community Health Diagnosis & Assessment.

If the state is serious about health reform, public health must have expanded funds to carry out technologically sound health assessment functions, which determine community and state health needs. These additional funds would be used to provide technical assistance to local health departments working on community health assessments. The recurring cost of this program to the state would be: $375,000 of which $43,000 is one-time cost.

d) Expanded Capacity -- HIV/AIDS Prevention & Care Coordination.

The state should expand funds to improve the availability and quality of case management services for persons living with HIV and AIDS and expand AIDS prevention work. The recurring cost of this program to the state would be: $2 million ($1 million for prevention, $1 million for care coordination).

e) Expand Safe Public Water Supply Program.

The state has been found to be out of compliance with the Safe Drinking Water Act of 1986 by the U.S. Department of Environmental Protection. EPA is threatening to take over the state's safe water program unless sufficient funds are provided to bring the state into compliance. The recurring additional cost of bringing the state into compliance with the Safe Drinking Water Act would be $2.4 million dollars.

3. *Create Community Health Districts (Community Health Districts, Public Health, Quality Controls).*

In order to address the current maldistribution of health resources and to coordinate the public and private health systems, the Commission recommends the establishment of 6-20 community health districts. Each community health district will have the responsibility of coordinating

private medical care services and public health services. CHDs will measure and produce annual public reports presenting health status indicators for populations within each respective district, and will have responsibility for planning, resource development and allocation, program evaluation and monitoring, etc. Where shortages of health care personnel or significant health risk to population exists, agencies must address this through cooperative and collaborative efforts with public/private agencies; failing this, CHD has authority to arrange for provision of these services.

CHDs will be given the responsibility of monitoring private insurance carriers and health plans operating in a community to assess how well the carrier or health plan is helping address community health needs. This information will be reported to the Department of Insurance, and used in licensure or relicensure decisions.

CHDs will also have the responsibility of assessing how well publicly funded health agencies, including public health and mental health, address community health priorities, and shall make recommendations to the appropriate state agencies on the distribution of public moneys.

4. *Use of home and community based services to enable a person to live at home or in the least restrictive environment for as long as possible.*

There are over 130,000 citizens disabled through mental retardation, other developmental disability or accident[16] and over 804,000 persons age 65 or older (1992).[17] The fastest growing segment of North Carolina's population is persons over age 85. Many disabled and older adults are well and live independently, however, the number of persons needing help with activities of daily living such as dressing, bathing, and toileting will increase dramatically as the population ages. Approximately 23 percent of those age 65 or older will need assistance with one or more activities of daily living; 57 percent of those age 85 plus will need assistance.[18] Many disabled and older adults and family caregivers prefer to have care provided at home. The North Carolina Health Planning Commission proposes that North Carolina continue to reduce fragmentation of services and increase the comprehensiveness and coordination of long term care financing and delivery so individuals receive care in the least restrictive environment that meets their needs.

The legislature has encouraged the Division of Aging, through the Home and Community Care Committee, to consolidate streams of funding to counties to facilitate more effective allocation in support of home and community services. The Health Planning Commission recommends that the Home and Community Care Committee submit a plan to the 1995 General Assembly for the consolidation of funding by all health and social service agencies of the state that would facilitate more effective provision of home and community care to the General Assembly.

E. MAINTAINING AND ENHANCING QUALITY CARE

Every resident and community in this state should be entitled to high quality health services designed to improve health status. To assure high quality health care requires careful monitoring and assessing the quality of care provided by different health providers and in different health

[16] presentation by Elise Bolda, Long Term Care Consultant, to the Long Term Care Subcommittee on June 15, 1994.

[17] Compiled by the NC Division of Aging May 1992, presented to the Long Term Care Subcommittee on June 15, 1994.

[18] The NC DHR Advisory Committee on Home and Community Care for Older Adults Third Progress Report March 1993.

settings. It requires monitoring both the care provided to those with insurance, as well as those who are uninsured. The methods used to evaluate the quality of services provided should be reviewed on an ongoing basis, and the services provided should be based on the most up-to-date health research and professional knowledge. The emphasis on quality is particularly important in the current context of cutting costs. As more emphasis is placed on cutting costs, there has to be a corresponding emphasis on ensuring quality. Without an emphasis on quality, health plans and providers may be driven to cut necessary services instead of cutting out unnecessary care, excess administrative costs or other waste in the system.

1. *Establish a Permanent Quality Improvement Commission with Responsibility to Monitor and Assure the Quality of Health Services in the State.*

The Commission recommends the establishment of a Quality Improvement Commission, similar to the Medical Database Commission, with oversight and rule making authorities. The Commission should be attached to the Health Planning Commission. The Commission members should be geographically and racially diverse, and should include members with different interests and expertise, including: consumers, providers, payers/employers, public health professionals, academicians/researchers, and insurance/health maintenance representatives. The Quality Improvement Commission will have the responsibility of assuring quality through every part of the health system and by all health providers, including private health providers, publicly funded agencies, health plans and insurance carriers, etc. They will have the authority to establish minimum quality thresholds for health plans and insurance carriers, to recommend practice guidelines to be used in North Carolina, and the content areas to be collected in report cards. The Commission must be ongoing, with the responsibility of monitoring quality measurements, and how well the standards help improve health status. The cost of this Commission will be $150,000 annually (to cover the costs of two staff members and Commission travel).

2. *Develop Report Cards to Compare the Quality and Value of Different Health Plans or Insurance Carriers, and in the Long Run, Hospitals and Individual Providers*

The Commission recommended the establishment of report cards, using nationally recognized data or measures to enable consumers and payers to compare the quality and value of services provided by different insurance carriers and health plans, and ultimately, hospitals and individual providers. The Quality Improvement Commission should develop multiple report cards: one for consumers and another for purchasers (e.g., employers). The content areas, may include the following areas: preventive services, prenatal care, public health measures, acute and chronic disease, mental health, functional status, access and satisfaction, health improvement programs, cost information, grievance information, enrollment and disenrollment information, and provider satisfaction data. The report card, which the Quality Improvement Commission develops should contain reliable and valid outcome variables that are severity adjusted.

3. *Establish Minimum Quality Thresholds which all Health Insurance Carriers and Health Plans Would be Required to Meet.*

The Quality Improvement Commission should establish minimum quality thresholds which all health insurance carriers and health plans would be required to meet. Minimum quality thresholds would assure the adequacy of care provided in all plans. The standards would apply to all health plans regulated in the state (including traditional major medical indemnity policies, HMOs, POS, PPOs, etc.), and eventually should cover ERISA plans. The standards would include structural, process, and outcomes requirements. The structural elements would include,

but not be limited to: financial solvency, ability to provide a full array of services, and minimum provider:patient ratios. The process standards would cover: continuous quality improvement, expertise in the use of high technology and expensive procedures, communications with members, grievance procedures, continuity of care when patients change providers, credentialing requirements, provider compensation disclosure provisions, reporting requirements for provider disenrollment for cause, publicly available utilization review criteria and practice guidelines, enrollment and disenrollment provisions, patient confidentiality protections, informed consent, ombudsman provisions, billing protections for patients, and marketing rules. Outcome measures would look at health status information and outcomes measures (such as those included in the Healthy Carolinians 2000 or HEDIS reports), as well as an assessment of how well plans address community health needs.

The Quality Improvement Commission will set the standards, as well as review the thresholds on an ongoing basis. However, the Department of Insurance or new Department of Health, when established, should monitor plans' compliance with the standards. Each health plan and selected contracting providers should be subject to on-site review at least once every three years, and more often, if needed. Cost to the state: eight new positions for the Department of Insurance to monitor insurance carriers and plans compliance with the quality thresholds.

F. EXPANDING THE STATE'S HEALTH INFORMATION AND DATA COLLECTION CAPACITY

To improve the quality of and access to health services while at the same time contain the cost of these services to the citizens of North Carolina, policy makers and health managers will need more sophisticated information support to make effective decisions. These decisions affect resource allocation, plan performance, and the implementation of new programs to fill the gaps currently existing in the State's delivery system. To help ensure that the consumer is better informed and to facilitate the changes occurring within the market, standardized provider performance information must be collected and made available to the public. Researchers will need a broader range of detailed health data in order to identify trends and establish clinically based performance measures. Practitioners and clinicians will need more timely access to information related to patient history and current treatment. Improved data collection and enhanced information systems were recommended by almost every Advisory Committee to the Health Planning Commission. The Commission recommends investing in a health data infrastructure that will lead to better public policy decision making and a more efficient private market, phasing in the Data and Information System over five years, according to the following schedule:

1. Year One (FY 95-96):

a) Establish the organizational infrastructure to coordinate various health information and data collection efforts .

i) Establish Health Data Policy Council.

The state should establish a Health Data Policy Council with responsibility to set policy and establish goals and guidelines for health data processing, collection, and analysis activities in the private and public sectors, and provide ongoing public oversight of the health data and information systems related activities. The Council should be comprised of representatives of the private and public sectors, representing health data users, suppliers, and collectors. The Council's primary responsibilities would be to coordinate health data management activities,

provide a mechanism for ongoing assessment of emerging technologies and applications, facilitate the utilization of data by coordinating access by multiple users of data which may be collected by several sources, and provide evaluation and recommendations to the General Assembly. The Council will include the members of the now existing Medical Database Commission, but with an expanded membership to broaden the representation. The health data policy functions currently undertaken by the Medical Database Commission Board would be assumed by the Health Data Policy Council. The Council should be attached to the Health Planning Commission.

Costs: The Council members will serve voluntarily. It is recommended that the Council have full-time staff of three to six individuals with an estimated cost of $200,000 to $350,000 annually.

ii) Redefine the role of the Medical Database Commission.

The staff and operational functions of the Medical Database Commission should be transferred to the Department of Insurance. The new MDC responsibilities should be expanded to include: (1) developing and endorsing licensure standards for health care transactions and data clearinghouses, Electronic Data Interchange (EDI) standards, security and confidentiality standards, unique identifier standards, coding conventions, data element standardization, and cost effective means of gathering data on all types of health care encounters (e.g. outpatient, homecare, nursing home, etc.); (2) facilitating data exchange among private networks; (3) becoming the portal for public access to needed health data; and (4) analyzing health data. Two new staff members will be needed to carry out the new responsibilities. The cost to the state for two new staff members to cover salaries and overhead would be $120,000 annually, less revenues the state would receive from licensing fees.

iii) Establish State Health Data Management Consortium.

Establish the State Health Data Management Consortium within the Health Planning Commission, consisting of a consortium of the managers of State agencies having health data related responsibilities as a major function, to better coordinate the collection and analysis activities of those agencies. While good now, coordination between agencies would be much improved if there was an on-going forum in which they could more effectively communicate. This would facilitate common data element definition, interpretation, and utilization. Standardization of technology application could also be improved if these agencies were provided the opportunity to exchange ideas and share common approaches to data collection, analysis, and telecommunications. Redundant data collection and analysis efforts could be more easily identified and eliminated. It is envisioned that the Consortium would have representation on and would supplement the staffing of the Health Data Policy Council for purposes of recommending and implementing policy related to health data collection and analysis.

There are no costs associated with this activity.

b) Unique Identifiers and Privacy Rights.

Require (a) the use of a unique patient identifier based on Social Security Number and (b) uniform application of nationally recognized standards for the unique identification of payers, providers, employers, third party administrators and utilization review organizations. In order to link patient, payer, provider, and employer data, and facilitate interactive and shared data bases, it is necessary to establish standards for the identification of each.

Use of the SSN as the patient identifier has become a near-standard for identification since it is used as such by major payers like Medicare, Medicaid, and numerous large commercial health insurance carriers. Several states (California, Florida, Iowa, Maryland, and South Carolina) have formally (through legislation) adopted the SSN as the patient identifier. Additionally, Veterans Administration and Department of Defense medical systems use SSN as the patient identifier.

There is no discernible cost to the state for this recommendation.

c) Privacy legislation.

Establish legislation to better assure the privacy, accuracy, and control of patient information. This would enable persons to: (1) know what information is being collected about them; (2) have access to records for the purpose of verifying accuracy; (3) submit corrective information; (4) limit the disclosure of information to authorized parties; and (5) that the patient/ consumer's right to privacy be assured as a legal right in State law. Redress for infringement of privacy should include penalties and costs.

There is no cost associated with this recommendation.

d) Provider related data.

Modify existing statutes and regulations to require (a) the submission of medical specialty, service location, and other health service information at license renewal and (b) annual renewal for all licensed providers (professional and institutional). Such information is necessary to track the availability of providers, determine which areas in the State suffer from inequitable access to specific types of health services, and anticipate future shortages which might adversely affect the citizens of the State. In collaboration with the various State licensing boards, review and assess the existing data collection practices relating to all licensed health professionals and institutions. Data collection tools should be revised as necessary to ensure a complete and accurate database on all licensed health care providers in the State.

Any cost associated with this recommendation should be able to be absorbed by the relevant licensing agencies and/or the fees they charge.

In addition, the Health Data Policy Council or the Quality Improvement Commission should study and provide recommendations with respect to the release of provider performance information, specifically as it relates to practice patterns and provider liability. There is concern that many of the initiatives for monitoring the quality of provider services may result in the release of information detrimental to the provider's practice and/or put the provider in a position of increased financial liability. While the public has a right to compare provider performance, providers also have a right to be protected from misuse of such information in a way that poses additional liability.

e) Begin to establish the technical infrastructure needed to reduce administrative costs of claims related transactions and provide for future electronic data collection.

i) Require electronic submission of health care information.

Accelerate Electronic Data Interchange (EDI) implementation by requiring at some point in the near future, that claims, encounters, remittances, eligibility verifications, and other health care related transactions be transmitted by electronic means by all health care providers, licensed insurers, managed care organizations, third party administrators, and other participants involved in the administrative processing of health care insurance and delivery transactions. Transition should be in accordance with ANSI X.12 standards, state specified data element requirements, and appropriate security measures to protect the confidentiality of patient information.[19]

Health care EDI can significantly reduce (or eliminate) paper claims and provide for more cost efficient processing of health services by enabling health information to be exchanged via electronic means. The Workgroup for Electronic Data Interchange (WEDI) study[20] predicts costs savings of $42 billion nationally through the implementation of electronic health care transactions. It is estimated that North Carolina's share of that savings could be as high as $1 billion based on prorated population once fully implemented.

Long term savings should offset most/all near term costs.

ii) Provide technical support for electronic submission of health information.

Establish a state sponsored program to provide technical, educational, and implementation assistance to providers and payers to accomplish the transition to the electronic data interchange (EDI) environment. This would be a fixed period program of about three to five years to assist payers and providers through education concerning EDI standards and technology implementation. The program could assist in the development of partnerships with private groups to promote EDI funding and utilization throughout the State.

The cost to the state would be $200,000 a year for three years. This includes a staff of three field personnel to provide education and assistance to providers. The costs include salary, travel and overhead. Collaborative ventures with private vendors may be able to reduce/eliminate these costs.

iii) Licensure requirements for commercial health care transaction clearinghouses.

Establish licensure requirements for commercial health care transaction clearinghouses for certification, appraisal, standardization, and the application of state mandated security measures to protect the confidentiality of patient information. Clearinghouses have the potential to

[19] ANSI in the American National Standards Institute which is one of the dominant organizations in developing national standards for technical areas. ANSI X.12 standards constitute the existing and emerging standards for health data transmission. Adoption of these standards will simplify electronic data interchange and reduce the costs associated with numerous proprietary formats currently being utilized.

[20] The Workgroup for Electronic Data Interchange (WEDI) was established in late 1991, following a forum convened by the Secretary of Health and Human Resources to address administrative costs in the nation's health care system. The initial report of the workgroup was issued in July 1992 with a follow-up report in October, 1993.

significantly facilitate the cost effective collection of health information, particularly ambulatory data. This benefit can be realized by capitalizing on current expenditures in the private sector at minimum public expense. But it requires a greater degree of standardization in operations than what currently exists.

The costs are included in the expanded Medical Database Commission staff budget request listed previously.

iv) Amend Medical Database Commission legislation to collect data from clearinghouses.

Amend enabling legislation for the data collection functions of the Medical Database Commission staff to allow collection of encounter data from health care transaction clearinghouses.[21] This will enable the State to collect payment as well as charge information and will facilitate identification of the applicable payer. This would also relieve providers of the burden and of the cost of providing encounter information as a separate function. Current legislation permits collection of encounter data from providers and payers.

The costs are included in the expanded Medical Database Commission staff budget request, listed previously.

2. *Year 2 (FY 1996-97):*

a) Begin utilizing technical infrastructure for more expanded health data collection:

Expand over time current data collection and analysis to include data from all ambulatory care sites. The expanded data collection needs to include (a) patient encounters relating to the delivery of primary care through physician offices, outpatient clinics, and public health clinics and (b) a minimum data set regarding the delivery of health care services via home health agencies. Initial phasing/testing might be on a sample basis or with larger networks/providers. Over time, expand this capability further to eventually collect data on all ambulatory medical treatments and health services provided within North Carolina, including those associated with indemnity, managed care, federal, self-funded, and state funded programs.

The cost to the state to collect all ambulatory transactions when fully implemented is estimated to be $5 million annually. Phased in costs are estimated at $2 million in FY 96-97 and $3 million additionally in FY 97-98 or over whatever longer period deemed appropriate of the initial testing.[22]

b) Implement health card standardization.

Require any health plan administrator who issues electronic patient identification card to have a magnetic stripe ōn the reverse, which includes the following information: social security number, name, address, next of kin, payer information, benefit coverage, pre-certification requirements,

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[21] Waivers may be needed to collect encounter data for the Medicare population. Further, ERISA may preclude mandatory collection of encounter data from self-funded plans, absent a change in federal law or a Congressional ERISA waiver.

[22] This assumes that the number of current transactions collected increases by about ten-fold. The $5 million pays for the collection and storage of ambulatory encounters.

the name of third party administrators and relevant phone numbers. Magnetic encoding should be in accordance with existing ANSI standards. It is anticipated that over time, most plan administrators will opt for electronic patient identification cards as a means for enrollee identification, leading to a fully electronic point-of-service eligibility verification capability. This would reduce administrative costs of the health delivery system and standardize electronic card formats used in the health delivery system.

Issuing electronic patient identification cards for the Medicaid population and the Teachers and State Employees would have a one-time cost of $1 million to the state, with an ongoing cost of $100,000 annually.

3. Year 3 (FY 97-98):

a) Extend technical infrastructure.

Connect current state health data repositories to the NC Information Highway in order to form a more widely distributed and immediately accessible health data network. Responsibility for the coordination of this effort should be designated to the Health Data Policy Council, which would also have oversight to insure compliance with applicable standards.

The cost to the state would be $250,000 on a one-time basis.

b) Community Health Information Networks.

Provide pilot project grants for three Community (local or regional) Health Information Networks (CHIN) in different communities of the State as demonstration projects. A CHIN network connects hospitals, labs, physicians, and other providers. It allows each to access the data of the others. As opposed to a central repository of all detailed patient information, a CHIN allows the information to remain at its source and be accessed by authorized participants when needed. Test results are available electronically as soon as they are entered. Any portion of an electronic medical record (history and physical, operative notes, discharge summary, etc.) can also be accessed through a CHIN. In a more sophisticated form, the CHIN can also be used to order tests, medications, and other services remotely from the provider's office. It also supports electronic consultation requests and referrals.

The proposed pilot projects are intended to identify and resolve these outstanding issues. The cost of this proposal would be $400,000 for the first pilot .[23]

c) On-line catalog of public and private health data resources.

Create an on-line catalog of available public and private health data repositories, analyses, reports and ongoing research efforts to facilitate access to health information via Internet or toll free telephone access. Much of the health information and ongoing research could be more effectively correlated and analyzed if participants could easily determine where information exists and what parties or agencies are conducting analysis in what areas. The catalog would not allow access to actual data but would enable researchers and analysts to determine if and where the data exists.

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[23] The cost of a pilot CHIN project would be approximately $2.0 million for each of three proposals. The state would be asked to help pick up 20 percent of the costs, with the remaining costs to come from private sources.

The cost of this proposal would be $100,000 on an annualized basis.

d) Begin utilization of enhanced data collection for health assessments.

As recommended elsewhere, the Department of Environment, Health and Natural Resources should establish a mechanism for ongoing assessment of the health status and health needs of all citizens within counties, community health districts, and other areas as appropriate. This supports a population based approach for the assessment and delivery of health care services including those covered by public health department services, managed care, the State Employee Health Plan, and all other benefit plans. Legislative authority is needed to ensure the adoption of a consistent and comprehensive model for health assessment that will be applicable to all geographically defined areas and sub-areas, with a capability to aggregate statistics to the state level. Within this model, the capability should be provided to assess health status for various population segments and sub-segments (gender, race, age, income, etc.).

There are no new costs associated with this proposal.

4. Year 4 (FY 98-99):

a) Create baseline.

Create a baseline against which to measure the impact of new policy initiatives. While the Commission strives to improve health status and quality, there is no state specific baseline against which to measure future progress towards achieving these goals. The baseline data which does exist are inadequate to properly assess current levels of access, quality of care, or delivery system performance. Progress in these areas cannot be effectively evaluated without knowing the point from which we are starting relative to all populations. Significant state moneys will be spent without adequate means to determine if they are being spent effectively.

There are no new costs associated with this recommendation.

b) Continuation of Community Health Information Network Pilot.

Continue the Community Health Information Network Pilot, described above. This will cost $400,000 for the second pilot.

5. Year 5 (FY 99-2000):

a) Continuation of Community Health Information Network Pilot.

Continue the Community Health Information Network Pilot, described above. This will cost $400,000 for the third pilot.

G. THE NEEDS OF SPECIAL POPULATIONS MUST BE SEPARATELY ADDRESSED

The state must design mechanisms to monitor the care provided to certain at risk populations. Historically, certain populations have experienced greater access barriers to care, and/or have worse health outcomes. For example, people of color are about twice as likely to be uninsured

than are whites in N.C.[24] Inadequate access to health care is one factor contributing to poorer health among minority groups in North Carolina. Women of color are more likely to have received inadequate prenatal care, have a higher percentage of low-birth weight babies, children born with birth defects, and infants who die before their first birthday.[25] Minority women are three times as likely to die of diabetes and cervical cancer than white women, and minority men have over twice the risk of death from diabetes as white men.[26] Similarly, even among people with insurance, minorities often suffer restricted access to health care. A study conducted of men enrolled in the Medicare program in North Carolina showed that whites were 4.7 times more likely to have coronary artery bypass than African-Americans.[27] Similarly, a 1990 North Carolina survey showed significant racial differences in the treatment provided to minorities diagnosed with diabetes.[28]

Similar problems exist for other special populations groups, including low income individuals, people with disabilities, children, the frail elderly, people living in rural isolated communities. The Commission recommends that the state establish a system to monitor and assess the quality of care provided to at risk populations--to ensure that the care received by the majority does not mask access or quality issues for specific subpopulations.

1. The General Assembly should codify a definition of special populations which can be used in data collection and community health assessments.

Special Populations face barriers to obtaining appropriate and needed health and support/enabling services. These barriers may arise because of: (1) exceptional medical, psychological and/or social conditions; (2) poor health status or perceived risk for poor health status; (3) access barriers to care arising from financial, cultural, linguistic, or personal concerns emerging from issues of lifestyle, education, employment and or housing and or (4) delivery system issues resulting from lack of available health care, geographic location, transportation limitations, and/or perceived or actual health system discriminations.

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[24] Based on analysis of current population survey data for North Carolina 1988-1990 performed by Chris Conover, Duke University Center for Health Policy Research and Education.

[25] Surles, Kathryn, K. Graham, D. Atkinson, *"Health Status of Blacks in North Carolina,"* CHES Special Report, N.C. Department of Environment, Health and Natural Resources, Oct. 1993. In 1993, for example, the infant mortality rate for whites was 7.9 deaths per 1,000 live births, and the rate for minorities was 16.4 deaths per 1,000 live births.

[26] North Carolina Center for Health and Environmental Statistics, "North Carolina Health Statistics Pocket Guide," 1993.

[27] Goldberg KC et al., *"Racial and Community Factors Influencing Coronary Artery Bypass Graft Surgery Rates for all 1986 Medicare Patients,"* Journal of the American Medical Association 1992; 267 (11) 1473-1477. The reported rate of heart attacks among whites was 1.6 times that for blacks. It is likely that this represents an undercount of heart attacks among blacks; even if it did not, whites are still proportionately far more likely to have bypass surgery.

[28] Surles, Kathryn, K. Graham, D. Atkinson, *"Health Status of Blacks in North Carolina,"* CHES Special Report, N.C. Department of Environment, Health and Natural Resources, Oct. 1993. The study showed that Minorities (86 percent) were less likely than Whites (98 percent) to receive a diet from the attending health care professional; and Minorities (80 percent) were less likely than Whites (93 percent) to have had their blood sugar checked on their visit to the doctor for diabetes care.

Special populations are found in every county and community in North Carolina. On the whole, they tend to evidence the above characteristics disproportionately to the general population. Special populations include, *but are not limited to*:

- racial and/or ethic minorities
- migrant and seasonal farm workers
- undocumented aliens
- persons with disabilities
- individuals at or below 200 percent of the federal poverty level
- the frail or vulnerable elderly, and
- uninsured and underinsured children

The State should officially designate the above groups as special populations. The State should mandate that public and private data collection efforts and community health assessments conducted by the state or its political sub-divisions gather and maintain data in a format to assess the health status of each of these population groups.

2. *Civil Rights legislation.*

The Commission recommends that the General Statutes be amended to prohibit participants in the health delivery system, be it the State, insurers, health benefits plans, pre-paid health plans, or providers from (1) refusing to insure, or provide service, or refusing to enroll in any benefits plan or; (2) limiting or reducing the amount, extent or kind of benefits, service or coverage based solely on that person's: race, color, age, gender, national origin, language, religion, socio-economic status, health status, real or perceived disability or anticipated need for services.

3. *Enabling or Support Services.*

Ensuring that every North Carolinian has health insurance coverage, does not ensure that every individual has meaningful access to needed health services. For example, an individual with insurance coverage, but without transportation to a care site or an understanding of how to appropriately access health services, is only slightly better off than a person who has no insurance. Therefore, the state must provide the support or enabling services which are needed to ensure access to health care. Enabling or support services are those which assist an individual or family in accessing and/or maximizing the effectiveness of health services, such as transportation, translation, or case management.

Each county should develop an interagency plan to coordinate and develop needed support services in a structured, systematic, and more efficient manner. The interagency plan must be developed with approval/ participation of health and service agencies, including local health departments, area mental health programs, Departments of Social Services, schools, local interagency councils, health advocacy organizations, Smart Start partnerships and most importantly consumers. Each plan must include coordinated approaches for outreach (information-referral), interpreter services, transportation and linkages between care coordination systems in place to serve specialized populations.

H. ONGOING WORK OF THE COMMISSION

1. Reorganization of the N.C. Health Planning Commission.

The Health Planning Commission, having completed its initial work, should be reorganized into a sixteen member Commission to monitor, assess and report to the people, the General Assembly and the Governor on the progress of health reform. The membership of the new Commission should include: the Governor or his designee, the Lt. Governor, the Speaker of the House, the President Pro Tempore of the Senate. Four additional members shall be selected by the Governor, four additional members shall be selected by the Speaker of the House (at least two of which shall be members of the House), and four additional members shall be selected by the President Pro Tempore of the Senate (at least two of which shall be members of the Senate). In addition to its ongoing responsibilities, set out in N.C.G.S. 58-68-21 et. seq., the Commission shall:

- Study ways to maximize employer based coverage;
- Study and report trends in the numbers of uninsured and underinsured, and access barriers;
- Monitor efforts to increase the purchasing power of government health programs;
- Study ways to maintain emergency medical services when hospital beds are reconfigured;
- Track current health expenditures and how closely it relates to the rate of real economic growth in the state;
- Analyze the impact of the Certificate of Need law changes;
- Review current Conflict of Interest laws;
- Assess the impact of the locum tenens laws;
- Monitor and assess the quality of care provided in the state;
- Review proposed definition of and rules for collaborative practice;
- Study effectiveness of different preventive health services.
- Other ways to expand coverage to the uninsured;
- Monitor numbers of people who lack access to primary care providers.

The Health Planning Commission shall report its findings and recommendations to the 1996 and 1997 session of the N.C. General Assembly. The cost of the reorganized Commission would be $875,000 annually. (Note: this is a reduction of the $1.5 million contained in the continuation budget.)

2. Summary of legislation to be introduced in the 1995 General Assembly:

a) Statutory changes.

The following recommendations will require statutory changes:

- Limiting preexisting condition limitations to six months for group products (Sec. A.2.a.1)
- Adjusted community rating changes (Sec. A.2.a.ii)
- Guaranteed issuance, renewability of all group products (Sec. A.2.a.iii)
- Portability between all health benefit plans with comparable insurance (Sec. A.2.a.iv)
- Regulation of stop-loss coverage (Sec. A.2.a.vi)
- Portability of non-group products (Sec. A.2.b.i)
- Limiting preexisting condition limitations to 12 months for non-group products (Sec. A.2.b.ii)

- Guaranteed issuance/renewability and adjusted community rating for non-group products (Sec. A.2.b.iii)
- Give Department of Insurance the authority to regulate private long-term care insurance (Sec. A.2.b.iv)
- Mandatory offering of three standard insurance products in group and non-group market (Sec. B.2)
- Mandatory use of Alternative Dispute Resolution system in malpractice cases (Sec. B.3.a)
- Pretrial screening in malpractice cases (Sec. B.3.b)
- Statutory qualifications of expert witnesses in malpractice cases (Sec. B.3.c)
- Sliding scale caps on attorneys fees in malpractice cases (Sec. B.3.d)
- Subrogation in malpractice cases (Sec. B.3.e)
- Recommended payment schedule for physical injury, and pain and suffering in malpractice cases (Sec. B.3.f)
- Eliminate statutory exemption of HMOs from CON process (Sec. B.4.a)
- Operating rooms in all locations and recovery beds in ambulatory surgery facilities subject to CON (Sec. B.4.b)
- Linear accelerators subject to CON (Sec. B.4.c)
- Regulating major medical equipment rather than diagnostic centers (Sec. B.4.d)
- Leasing of major medical equipment subject to CON (Sec. B.4.e)
- Amend Hospital Cooperation Act to apply to all health care providers (Sec. B.5.a)
- Remove restrictions preventing joint ventures between public and private health care facilities (Sec. B.5.b)
- Creating human resource authorities (Sec. C.4.d)
- Carriers or health plans that offer in one part of region must offer services throughout the entire region (Sec. C.4.a)
- Essential community providers allowed to serve in managed care networks for three years (Sec. C.4.b)
- Enact statutory definition of primary health care (Sec. C.5.a)
- Amend N.C.G.S. 143-613(a)-(e) to include plans from health professional schools regarding methods to increase numbers of mid-level primary care providers (Sec. C.5.c)
- Prohibit insurers from discriminating against practices owned in part or in whole by nurse practitioners, physician assistants or nurse midwives practicing in scope of their practice (Sec. C.5.d)
- Mandate coverage of prenatal, well child care, and immunizations (Sec. D.1)
- Create Community Health Districts (Sec. D.3)
- Giving the Quality Improvement Commission the authority to establish minimum quality thresholds (Sec. E.3)
- Redefining role of the Medical Database Commission (Sec. F.1.a.ii)
- Establish State Health Data Management Consortium (Sec. F.1.a.iii)
- Require use of unique patient identifier number (Sec. F.1.b)
- Enact legislation to assure privacy, accuracy and control of patient information (Sec. F.1.c)
- Require submission of medical specialty, service location and health service information during annual license renewals (Sec. F.1.d)
- Require electronic data interchange (Sec. F.1.e.i)
- Establish licensure requirements for commercial health care transaction clearinghouses (Sec. F.1.e.iii)
- Amend enabling legislation for Medical Database Commission to allow collection of encounter data from health care transaction clearinghouses. (Sec. F.1.e.iv)

- Codify definition of special populations to be used for data collection and community health assessments (Sec. G.1)
- Enact legislation prohibiting discrimination in health care system (Sec. G.2)
- Enact legislation requiring coordination of enabling services at county level (Sec. G.3)

b) Appropriations bill or special provision.

The following recommendations will require appropriations bills or special provisions:

- Expand Medicaid coverage to more children, pregnant women, elderly and disabled according to a priority list (Sec. A.1.a-k)
- Annual survey of uninsured and underinsured (Sec. A.3)
- Enhance Medicaid reimbursement to primary care providers serving in medically underserved areas (Sec. C.1)
- Creation of provider incentive fund, giving Office of Rural Health and Resource Development flexibility of using existing funds for recruitment and retention purposes (special provision) (Sec. C.2.a)
- Establishment of *in locum tenens* program in NC Office of Rural Health and Resource Development (Sec. C.2.b)
- Expand new and existing rural health primary care system (Sec. C.3.a)
- One-time biennium funding to expand existing rural health primary care system (Sec. C.b)
- Planning grants to develop integrated service networks (Sec. C.3.c)
- Reallocate existing budgets of state medical and health professional schools to expand primary care educational programs (Sec. C.5.b)
- Provide additional financial support to health professional schools that offer outreach programs or courses during nontraditional hours (Sec. C.5.b)
- Healthy Community block grant (Sec. D.2.b)
- Expanded capacity for Community Health Diagnosis and Assessment (Sec. D.2.c)
- Expanded capacity for HIV/AIDS prevention and care coordination (Sec. D.2.d)
- Expand Safe Public Water Supply program (Sec. D.2.e)
- Redefine and expand role of Medical Database Commission staff (Sec. F.1.a.ii)
- Establish state health data management consortium (special provision, no appropriation needed) (Sec. F.1.a.i)
- Provide technical assistance to providers and payers to ease transition into electronic data interchange (Sec. F.1.e.ii)

c) Statutory changes and appropriations.

The following recommendations will require both statutory changes and appropriations bills:

- Amend GS 131A to allow Medical Care Commission to provide partial loan guarantees to accommodate smaller, higher risk health care organizations (Sec. B.6.a)
- Establish permanent Quality Improvement Commission (Sec. E.1)
- Giving the Quality Improvement Commission the authority to establish report cards (Sec. E.2)
- Establish a Health Data Policy Council (Sec. H.1)

d) Studies.

The following recommendations must be studied further, and reported back to the N.C. General Assembly.

- Study ways to maximize employer based coverage (Sec. A.2.a.vii)
- Study and report trends in numbers of uninsured (Sec. A.3)
- Study ways to increase purchasing power of government financed health programs (Sec. B.1)
- Study feasibility of a no fault malpractice system (Sec. B.3.g)
- Study incentives needed to maintain emergency services when hospital beds reconfigures (Sec. B.6.c)
- Study health expenditures to determine how closely the increases in health costs parallel the rate of real economic growth (Sec. B.7)
- Review conflict of interest legislation to determine if further legislation needed (Sec. B.8.b)
- Establish definition of and rules for collaborative practice (Sec. C.5.d)
- Effectiveness of other preventive health services (Sec. D.1)
- Study capacity of smaller, low-wealth counties to meet core public health functions (Sec. D.2.a)
- Study ways to release provider performance information (Sec. F.1.d)

e) General support.

The following recommendations include general support for the concept, but no legislation is needed:

- N.C. State Health Plan Purchasing Alliance Board (Sec. A.2.a.v)
- NC Information Superhighway (Sec. B.8)
- Home and Community Care Committee submit a plan to the 1995 General Assembly for the consolidation of funding by all health and social service agencies of the state that would facilitate more effective provision of home and community care to the General Assembly (Sec. D.4)

Appendix A

Benefits Committee
Basic, Intermediate, and Expansive Packages

BASIC PLAN

Cost Sharing Requirments	Amounts
Deductibles (Individual/Family Deductibles)	$500/$1500
Coinsurance: Hospital - Inpatient Hospital - Outpatient Professional - Inp. Professional - Outpat. Misc.	 40% 40% 40% 40% 40%
First Six Office Visits/Year Primary Care Mental Health or Substance Abuse	 $5 per visit $10 per visit
Out-Of-Pocket Maximum (Individual/Family Maximum)	$2900/$8700
Out-Of-Network Coinsurance	50%
Lifetime Maximums	None
Claims Cost Per Individual	
Target Claims Cost/Month	$88
Actual Claims Cost/Month	$81.56
Premiums	
Individual	$114.96
Individual with Children	$202.04
Couple	$221.23
Couple with Children	$350.44

INTERMEDIATE PLANS

Cost Sharing Requirments	Intermediate Plan Coinsurance Design	Intermediate Plan Copayment Design
Deductibles	$250/$750	None
Coinsurance:		
Hospital - Inpatient	20%	NA
Hospital - Outpatient	20%	NA
Professional - Inp.	20%	NA
Professional - Outpat.	20%	NA
Misc.	20%	NA
Copayments:		
Inpatient Per Diem	NA	$200/$2000
Outpatient/ER Per Visit	NA	$ 80
Office Visits	NA	$ 25 ($35)
Prescription Drugs	NA	$ 15
Out-Of-Pocket Maximum	$1250/$3750	NA
Out-Of-Network Coinsurance	40%	40%
Lifetime Maximums	None	None
Claims Costs Per Individual		
Target Claims Cost/Month	$105	$105
Actual Monthly Claims Costs	$104.99	$104.99
Premiums		
Individual	$148.32	$148.32
Individual with Children	$261.39	$261.39
Couple	$284.63	$284.63
Couple with Children	$446.40	$446.40

EXPANSIVE PACKAGE

Cost Sharing Requirments	Expansive Plan Coinsurance Design	Expansive Plan Copayment Design
Deductibles	$150/$450	None
Coinsurance:		
Hospital - Inpatient	10%	NA
Hospital - Outpatient	10%	NA
Professional - Inp.	10%	NA
Professional - Outpat.	10%	NA
Misc.	10%	NA
Copayments:		
Inpatient Per Diem	NA	$100/$1000
Outpatient/ER Per Visit	NA	$ 50
Office Visits	NA	$ 10 ($16)
Prescription Drugs	NA	$ 10
Out-Of-Pocket Maximum	$650/$1950	NA
Out-Of-Network Coinsurance	30%	30%
Lifetime Maximum	None	None
Claims Cost Per Individual		
Target Claims Cost/Month	$126	$126
Actual Claims Cost/Month	$146.32	$146.32
Premiums*		
Individual	$211.70	$211.70
Individual with Children	$345.39	$345.39
Couple	$408.16	$408.16
Couple with Children	$589.68	$589.68

* Note, the premium costs for the expansive package would be higher if long term care coverage is optional. The long term care costs built into this package were premised on the assumption that these services would be provided as part of a mandated package provided to all North Carolinians under universal coverage. The costs of this package would be significantly higher if individuals are left with an option to purchase this coverage; as there likely would be significant adverse-selection (i.e., those individuals most in need of long-term-care services would purchase this coverage; while younger, healthier individuals would opt against paying these additional costs).

Appendix B

Primary Care Questions and Answers

Using the Definition of Primary Care:

The definition of Primary Care adopted by the Committee sets a high standard for primary health care. Very few practice settings now in existence can claim to meet the definition in all details at all times. At the same time, it is a definition which all primary health care providers can endorse and strive to meet. The primary health care provider must be responsible for bringing to each individual seeking his/her care high standards of preventive care, acute care for new complaints, and care for chronic illness and for selecting appropriate professional assistance when the problem is beyond his/her scope of knowledge and skills.

This discussion and the following questions and answers are provided for clarity and to address those questions which recur regularly in discussions of this topic with clinicians. It is not recommended that the following text be enacted as part of the definition of primary care.

It should be understood that the attributes identified in the definition are considered as essential components of primary health care. A provider who offers one or two but not all of these required components is not performing primary health care. These attributes must not be considered as measures of primary health care quality. Ascertaining that they are present in a practice setting is essential in determining **whether** primary health care is being provided, not **how well** it is being delivered. At the same time, each of the attributes can be measured and monitored and used to improve the quality of services over time. The questions and answers below contain several examples of consensus- derived "thresholds" for determining whether or not a provider delivers a required attribute. These were not based on a wide sampling of the primary health care provider community but are offered as a consensus opinion of the members of the Committee and the beginning point for discussion of these issues and for further research on the effect of these attributes on the quality of primary health care outcomes.

1. CONTINUING CARE

Q. I am an emergency room physician. In my community, there are many people who have no regular source of medical care, and they come to the emergency room for all varieties of health problems, from minor colds to heart attacks. As the provider of first level to this large group of our citizens, am I providing primary health care?

A. No. The situation you describe is commonly encountered in our state as a result of the shortage of primary health care providers. However, most emergency rooms do not assume the ongoing responsibility for follow-up, nor do they provide the preventive care which must be the foundation for primary health care. You are providing urgently needed services, but they are not primary care.

Q. I work in an urgent care center. We see patients during our work hours and are often the first contact with medical care in an acute illness or injury. We also provide preventive services, such as Pap smears, when these are requested by the patient. Are we providing primary health care?

A. No. As in the above case, you do not assume responsibility for establishing and maintaining an ongoing relationship with the individual and for setting up a treatment plan over time.

Q. My office is a very busy place and while we attempt to carry out the recommended preventive procedures, our patients often fail to keep appointments for these procedures, or fail to complete the tests. Is it our responsibility to review our charts and to make sure that our patients have completed these preventive services?

A. Yes, as a primary health care provider, you have the responsibility to review your records at regular intervals and to remind those you serve that they have not completed the indicated procedures. At a technical level, this is difficult in an office without a computer-based record system. This will almost certainly be the practice standard in the future. In the meantime, some system for regular review of your records should be implemented. We all recognize that some individuals will not follow recommendations, even though this has been discussed and agreed to at an earlier point. Documentation of the fact that you have reminded the individual of the need for the preventive service is always prudent.

2. COMPREHENSIVE CARE:

Q. I am an obstetrician-gynecologist, and I provide care for a large number of women from late teens onward. My training included very little on the usual medical illnesses, so I refer most of my patients who present with medical problems, such as fever, chest pain, severe headaches, etc., to an internist or family physician. Do I meet the criteria for primary health care?

A. No. Your lack of exposure to the common medical illnesses in your residency points out a common problem. Many OB-GYN residencies place most emphasis on surgical and obstetrical illnesses and do not prepare the physician to handle the more common medical problems which present to the primary health care provider. Some California primary care programs are now providing graduates of such residencies a special course of study to add to these skills. At the present time your practice does not provide the level of comprehensiveness expected of a primary health care provider.

Q. I am a pulmonologist, and my patients all suffer from pulmonary problems. Most of my patients are seen in consultation with other physicians, but many look to me as their only source of care. For these, I provide a full scope of services, such as would be provided by an internist. Do I qualify as a primary health care physician?

A. You may provide primary health care to certain of your patients, but since you do not offer such services to all, or even most, of your patients, then you cannot be classified as a "primary health care physician." The services you provide are obviously of great value to your patients, but most physicians in practices such as yours find that it is not practical to provide a full spectrum of services, such as preventive counseling and hospitalization for nonpulmonary medical illnesses, all of which would be handled by most general internists.

Q. I am an internist and have a busy practice. I find that my work day will not allow me to see patients at the office and hospital and also to follow patients who have

been admitted to nursing homes. For this reason, I do not follow patients who are in rest homes and nursing homes. Do I meet the criteria?

A. Your problem is not an uncommon one. Your patients could choose any of several nursing homes scattered over many miles. Maintaining relationships with one or two conveniently located nursing homes would provide these services to those frail patients who want to continue their relationship with you, but it is not reasonable for you to cover patients in a half dozen widely dispersed homes. If your patient elected to go to a town a hundred miles away, you would not be expected to maintain the relationship, but you should assist the family and patient by assisting in the acquisition of a new provider and in providing all relevant records to that provider to smooth the transition. If you categorically terminate your relationship with all patients who need care in a nursing home and leave the responsibility for finding a new provider with the family or the nursing home, you do not provide an acceptable level of continuity which would qualify you as a primary health care provider.

3. INTEGRATED CARE:

Q. I am a family physician, and I refer patients with diseases which require knowledge beyond my level to specialists in the area. Many times the patient will return to me to discuss a decision, or to ask about new symptoms. I feel that the specialist is being well paid to handle such questions and discussions. Is this part of my responsibility as the patient's primary health care provider?

A. Yes, you are expected to continue to provide primary care for the patient and to coordinate such care with that being provided by the specialist. You may not have the complete knowledge to answer a detailed question about the treatment given by the specialist, but your obligation as a primary health care physician extends to being the patient's agent in securing information.

Q. I am a physician assistant in a community health clinic. I have referred several patients to a cardiologist in a nearby community. He does a good job with heart-related problems but does not pursue indicated preventive procedures such as pap smears and mammograms. Is this my responsibility as the primary health care provider?

A. Yes, definitely. Unless you have an explicit agreement with the patient that he/she is leaving your care for another primary care provider, it is your responsibility to coordinate the care provided by the consultant with your own.

4. ACCESSIBLE CARE:

Q. I am a family physician in a rural area and have no partners with whom I can cross cover. To preserve my family relationships and to prevent total burnout, I do not provide night call coverage, but I ask my patients to report to the nearest emergency room in case an emergency arises. Does this meet expectations for primary health care?

A. No, your practice does not provide "any-hour, day-or-night" access. It would be wonderful if there were enough providers so that you could work out cross coverage arrangements to provide such services for your patients, and we hope you can soon do so. In the meantime, you could meet this criterion by making specific

arrangements with the emergency room which most of your patients would choose as follows: (a) arrange with the ER to see your patients and with a specific physician or group to be called if hospitalization is necessary; (b) provide your patients with an explanation of these arrangements; (c) provide instructions on your telephone system as to how a patient who calls after hours can access the system; and (d) arrange for the covering ER and covering physicians to provide you a summary of any patient contact which they provide for one of your patients so that you are informed of the incident and add this information to that individual's medical record. Realize that this is a stop-gap arrangement and does not represent ideal primary health care.

Q. I am a nurse practitioner in a county health department. The department closes at 5 PM and provides no night call coverage. Do I meet this criterion?

A. No. As above, the practice does not provide "any-hour, day-or-night" access. Your supervising physician may be a community provider and may be willing to provide the night coverage. If the supervising physician is unable to provide this service to your patients, you may make arrangements with another community group which can do so. ER arrangements, such as those described above, may be the next best solution. In any case, your responsibility as a primary health care provider includes setting up arrangements, letting your patients know of these arrangements, providing some information about these arrangements for the patient who calls at night and making arrangements for feedback to you of information about such patient contacts.

Q. I am an internist, but my patient load is so great that I am unable to provide a routine, nonemergency appointment in less than two months. Do I meet this requirement?

A. No. Most physicians and all patients would agree that you are not providing appointments in a reasonable time frame. As in the above examples, your plight is understandable, and it is regrettable that you cannot add partners to assist you in your practice. Have you considered adding a physician assistant or nurse practitioner to enlarge the capability of your practice and better serve your patients? Have you considered an experienced person, such as a nurse, who could talk to those patients who call for such appointments, providing a method of prioritizing among those who call for appointments? Most would consider a wait of a week or two for a truly nonemergency problem as reasonable, and you should realize that anything less than that is stop-gap and not ideal primary health care.

5. TECHNICALLY SOUND CARE:

Q. I work in a health department and some nurse practitioners, trained in one field such as family planning, are pressed by load and circumstance into providing services for which they are not prepared, such as pediatric care. They are doing the best they can, but is this practice acceptable?

A. It is the obligation of a primary health care practice to periodically evaluate the skills and ability of each member of the team and to correct any deficiencies uncovered. This would include the nonprovider clerical and technical staff of a practice. For example, all should be trained in CPR and in universal precautions for prevention of blood-and-body-fluid-transmitted diseases. It is the responsibility of the practice to insure that no provider or staff member is asked to do tasks for which he/she has not been trained to perform.

Q. As a responsible family physician, I try to provide all the recommended preventive services to my patients. I am confused by variations in recommendations provided by various expert groups. An example is the variation between the starting point for mammograms as recommended by the American Cancer Society and the U.S. Preventive Services Task Force. How am I to judge the "technical soundness" of my services in the face of this confusion?

A. The differences between the recommendations of recognized experts is confusing, and we all hope that these can be resolved by further research. In the meantime, you should read the available, research-based information which guided these experts to their conclusion and be able to justify the one which you choose, both to yourself and to your patients. There are many areas in which current information is inadequate. This underscores the obligation of the primary health care clinician to remain current in his/her professional knowledge and skill, through reading, attendance at postgraduate educational exercises and through consultation with colleagues.

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